Otolaryngology Specialists of North Texas
Pediatric and Adult Ear, Nose, & Throat Specialists

Dr. Rohn and Dr. Gamble
6300 W Parker Rd Suite G24
Plano, TX 75093
972-378-0633

7515 Greenville Ave Suite 410
Dallas, TX 75231
214-239-1641

Patient Intake Form- Pediatric **Date:**_____

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Date of Birth ____/____/_____

Age _____ Sex _____ SSN :_____Race _____ Ethnicity ____Hispanic _____Not Hispanic

Address _____ Apt # _____ City _____ State _____ Zip _____

Email Address _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Work Phone _____

How may our office best contact you? (Check one) _____Home Phone _____Cell Phone _____Work Phone

Preferred method of appointment reminder? _____Text _____Phone (circle: cell or home)

PARENT/GUARANTOR INFORMATION

Name_____ Relationship to Patient _____SSN_____ Date of Birth_____

Address_____City/State/Zip_____Email Address_____

Home Phone_____ Cell Phone_____ Work Phone _____

Occupation_____ Employer_____

PHARMACY

Pharmacy Name _____ Phone _____ Fax _____

Address _____ City/State/Zip _____

INSURANCE INFORMATION

Primary Insurance Carrier _____

ID# _____ _____

Group # _____

Subscriber Name _____

Subscriber SS # _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

Secondary Insurance Carrier _____

ID# _____

Group # _____

Subscriber Name _____

Subscriber SS# _____

Subscriber Birth Date _____

Relationship to Patient _____

Employer _____

REFERRING PHYSICIAN

Physician Name _____ Practice Phone _____

May we thank someone else (non-physician) for referring you to our office? _____

ALLERGY INFORMATION

Drug Allergies _____Environmental Allergies_____

Are you allergic to latex? _____ Yes _____ No

Are you allergic to medical tape? _____ Yes _____ No

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Attend day care _____Yes _____No Pets in home _____Yes _____ No Cigarette Smoke exposure _____Yes _____No

MEDICATION

Please list all medications you are currently taking including over the counter medications, herbals, etc.

____ No Current Medications

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

Medication_____ Reason for Taking _____

HEALTH HISTORY

What problems are you here for today? _____

Do you currently have or frequently experience:

____Allergy Problems	____Birth Defects/Syndrome	____Immune Deficiency	____ Respiratory
____Asthma	____Bleeding Disorders	____Heart Problems	____ Speech/Language Delay
____Anesthesia Problems	____Developmental Disorders	____ Neurological Problems	

____Other:_____

Birth History Was your child born premature ____Yes ____No Gestational age at delivery _____

Complications of Prematurity _____

Prenatal Complications _____Current Weight _____Immunizations up to date ____Yes ____No

Did child pass newborn hearing screen ____Yes ____No ____Unsure Any current therapy (PT/OT/Speech)_____

Have you undergone any of the following surgeries?

Tonsillectomy	Date: _____	Adenoidectomy	Date:_____
Ear Surgery	Date: _____	Thyroid Surgery	Date:_____
Ear Tubes	Date: _____	Nasal/Sinus Surgery	Date:_____

Other_____

FAMILY HISTORY

Has anyone in your family had: M=Mother, F=Father, S= Sibling, MGM= Maternal Grandmother, MGF= Maternal Grandfather, Paternal Grandmother, Paternal Grandfather

____Alcoholism	____Cancer	____Heart Attack	____Lung Problem
____Anemia	____Chronic Ear Infections	____Heart Failure	____Mental Illness
____Arthritis	____Depression	____Hepatitis	____Reflux
____Atrial Fibrillation	____Diabetes	____High Blood Pressure	____ Sleep Apnea
____Asthma	____Emphysema	____High Cholesterol	____ Stroke
____Birth Defects	____Epilepsy/Seizures	____HIV/AIDS	____ Thyroid Problem
____Bladder Disease	____Glaucoma	____Kidney Disease	____Tuberculosis
____Bleeding Disorder	____Headaches	____Liver Problem	____Weight Loss/Gain

Other: _____

Patient Name:_____Date of Birth: _____

PATIENT REVIEW OF SYSTEMS

Do you frequently have or frequently experience: (Please check ALL that apply)

General	**____Healthy**	____ Prematurity	____Failure to thrive	____Fatigue
		____Fever	____Weight Gain	____Weight Loss
Review of System	**____None**	____Hyperactivity	____Attention deficit	____Anxiety
		____Depression		
Allergy/Immunologic	**____None**	____Reactions	____Itching	____Sneezing
		____Eye Irritation	____Immune Problems	____ Other: _____
Eyes	**____None**	____Strabismus	____Diminished visual acuity	
		____Discharge	____Other	
Ears, Nose, Throat & Mouth	**____None**	____ Bruxism (teeth grind)	____Nose Blocked	____Voice Changes
		____Pressure in ear	____ Difficulty Swallowing	
		____Nosebleed	____Ringing in ears	____Sinus Pain
		____Sore Throat	____Other:_____	
Endocrine	**____None**	____Hormone Problems		____Growth Disturbance
		____Other:_____		
Respiratory (Lungs)	**____None**	____Cough	____Shortness of Breath while Sitting	
		____Wheezing	____Shortness of Breath with Exertion	
Cardiovascular (Heart)	**____None**	____Heart Murmur	____Syncope	____Chest Pain
		____Cyanosis	____Irregular heart beat	____Other:_____
Gastrointestinal	**____None**	____GERD	____Constipation	____Diarrhea
		____Indigestion	____Nausea	____Vomiting
Hematologic/Lymph Nodes	**____None**	____Anemia	____Blood disorder	____Bleeding easily
		____Easy bruising		
Genitourinary	**____None**	____Urination at Night		
		____Kidney Problems		____Other:_____
Musculoskeletal	**____None**	____Fractures	____Bone disease	____Painful Joints
		____Weakness		
Integumentary	**____None**	____Dry Skin	____Eczema	____Itchy skin
		____Rash		
Neurological (Nerves)	**____None**	____Meningitis	____Head Injury	____Dizziness/Vertigo
		____Headache	____Seizures	
Psychiatric	**____None**	____Hyperactivity	____Anxiety	____Depression
		____Other:_____		

Patient Comments: _____

_____

Signature of Patient/Guardian _____Date_____

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6300 W Parker Rd, Suite G24 Plano, TX 75093
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Authorizations and Releases

By signing this consent form, I acknowledge that I have read, understand and/or authorize the following:

Authorization of Treatment:
I certify that I am the patient or the parent/legal guardian of the patient, and I consent to the administration and cost of all medical and surgical procedures, x-ray and medication for myself and for my dependents.

Guarantee of Payment:
_____ Initial if **SELF PAY**: I elect to pay for all services rendered in full on the date of treatment. I understand that my insurance will NOT be billed by Otolaryngology Specialists of North Texas (the "Practice").

_____ Initial if **INSURANCE** – **Assignment of Benefits:** I authorize payment directly to The Practice for all benefits otherwise payable to me. I also acknowledge that the Practice will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and current contract with my insurance carrier. I understand this is only an estimate, and, after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. I understand he Practice cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Receipt of Financial Policy:
By signing this consent form, I acknowledge that a copy of the Financial Policy of the Practice is available to me upon request and can be downloaded at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Receipt of Privacy Practices/HIPAA & Release of Health Information:
By signing this consent form, I acknowledge that a copy of the Practice's Notice of Privacy Practices ("NPP") has been made available to me, I am entitled to receive a copy upon request and I may download the NPP at www.entkidsadults.com. I understand that a copy of this consent form may be used with the same effectiveness as the original.

I understand that the Practice may use and/or release my health information verbally, in writing, electronically or otherwise for treatment related functions, payment for services, for quality review purposes and any other purposes specifically permitted or required under HIPAA and as described in the Practice's NPP.

___I request my health information be shared with _____Relationship to Patient_____

I authorize the Practice to leave messages for the patient about appointment reminders or instructions regarding patient care at the following **phone number**: _____.

Surgery Center Disclosure:
I understand that the physicians of the Practice are affiliated as owners with, and have financial interest in the following surgery centers or hospitals: Texas Institute of Surgery, Texas Health Center for Diagnostics and Surgery and Cook Children's Pediatric Surgery Center). The physicians may receive an indirect financial benefit if you are referred to any of these facilities. I understand that I have the option to use an alternate facility and the Practice will not treat me differently if I choose to use an alternate facility.

I may revoke consent for any or all of the above items at any time, in writing. I certify that all information provided to the Practice is correct.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date